53900. General.

(a) In defined geographic areas designated by the department, health care services shall be provided to eligible beneficiaries as follows:

(1) Medical services shall be provided through Prepaid Health Plans (PHPs) and Primary Care Case Management (PCCM) plans.

(2) Dental services shall be provided through dental-only Knox-Keene licensed PHPs.

(b) PHPs, PCCM plans, and dental plans participating in the Geographic Managed Care (GMC) program shall meet the requirements contained in this chapter and the PHP and PCCM plan requirements contained in chapters 4 and 6, respectively, of this subdivision. If the requirements in this chapter and those in chapters 4 and 6 conflict, this chapter shall take precedence.

53902. Definitions.

The following definitions shall control the construction of this chapter, unless the context requires otherwise.

(a) Assignment. Assignment means the actions taken by the GMC enrollment contractor to enroll an eligible beneficiary into a GMC plan, in the absence of a selection made by the beneficiary. Assignment also means action by a GMC plan to assign a member to a primary care provider, in the absence of a selection made by the member.

(b) Capitated Service. Capitated service means a medical or dental service for which a GMC plan is compensated in its fixed monthly per member rate.

(c) Dental Plan. Dental plan means a specialized health care service plan, which provides only dental services and is licensed under the Knox-Keene Health Care Services Plan Act of 1975.

(d) Eligible Beneficiary. Eligible beneficiary means a person who resides in an area covered by the GMC program, who has been determined eligible to receive Medi-Cal services, whose scope of Medi-Cal benefits is not limited, and who has been determined to have a share of cost equal to zero, as specified in Section 53906.

(e) Fair Hearing. Fair hearing means an administrative hearing conducted by the state relating to Medi-Cal eligibility or benefits, pursuant to Sections 50951 through 50955.

(f) Federally Qualified Health Maintenance Organization (HMO). Federally qualified HMO means a PHP that has been determined by the federal Health Care Financing Administration to be a qualified HMO under Section 1310(d) of the Public Health Service Act.

(g) Geographic Managed Care (GMC) Program. GMC Program means the program authorized by Section 14089 et seq. of the Welfare and Institutions Code.

(h) GMC Contract. GMC contract means the written agreement entered into between a prepaid health plan, primary care case management plan, or dental plan and the department to provide health care services to GMC plan members.

(i) GMC Enrollment Contractor. GMC enrollment contractor means the entity contracting with the department to provide GMC options presentations, enrollment and disenrollment activities, and problem resolution functions.

(j) GMC Plan. GMC plan means a PHP, PCCM plan, or dental plan that has entered into a GMC contract with the department.

(k) Indian. Indian means any Indian who is eligible under federal law to receive health services provided directly by the United States Indian Health Services (IHS) or by a tribal or urban contractor through contract with IHS.

( l) Indian Health Service Program Facility. Indian Health Service program facility means a tribal or urban Indian Health Service (IHS) organization operating health care programs or facilities with funds from the IHS under the Indian Self-Determination Act and the Indian Health Care Improvement Act, through which services are provided, directly or by contract, to the eligible Indian population within a defined geographic area.

(m) Initial Health Assessment. Initial health assessment means an assessment conducted by the GMC plan of a member's medical or dental health status.

(n) Member. Member means an eligible beneficiary who is enrolled in a GMC plan.

(o) Prepaid Health Plan (PHP). PHP means a health care service plan licensed pursuant to the Knox-Keene Health Care Service Plan Act of 1975, which has entered into a contract with the department on a capitated rate basis to furnish health services to eligible beneficiaries.

(p) Primary Care Case Management (PCCM) Plan. PCCM plan means a primary care provider that has contracted with the department pursuant to Article 2.9, commencing with Section 14088, Welfare and Institutions Code.

(q) Primary Care Provider. Primary care provider means a physician or dentist who has the responsibility for providing initial and primary care to members, for maintaining the continuity of member care, and for initiating referrals for specialist care.

(r) Service Site. Service site means the location designated by a GMC plan at which a member received primary care physician or dentist services.

53904. GMC Plan Requirements.

(a) Each GMC plan shall:

(1) Agree to provide or arrange for the provision of, to the extent allowed by state and federal law, the scope of Medi-Cal program benefits set forth by GMC contract to eligible beneficiaries who either select or are assigned to that GMC plan.

(2) Share in the risk of providing health care services.

(3) Provide readily available and accessible health care services and utilize preventive health care programs to improve the health status of its members.

(4) Case manage members' utilization of health care services.

(5) Inform eligible beneficiaries about non-medical transportation services that may be available to them under the Medi-Cal program, including the conditions under which non-medical transportation services will be provided to members by the GMC plan and how a member is to request those services, if the plan opts to provide them.

53906. Eligible Beneficiaries.

(a) Enrollment in GMC plans shall be mandatory for eligible beneficiaries who meet all of the following criteria:

(1) Are eligible to received Medi-Cal services that are not limited in scope;

(2) Have been determined to have a share of cost equal to zero;

(3) Do not meet the criteria for selecting an alternative to GMC plan enrollment, specified in Section 53923.5;

(4) Are eligible for any of the following:

(A) Programs linked to the Aid to Families with Dependent Children (AFDC) program, as defined in Section 50019;

(B) The Medically Indigent program for children under age 21, as defined in Section 50251(a); or

(C) Foster Children program.

(b) Enrollment in GMC plans shall be voluntary for eligible beneficiaries who meet all of the following criteria:

(1) Are eligible to receive Medi-Cal services that are not limited in scope;

(2) Have been determined to have a share of cost equal to zero; and

(3) Are eligible for either of the following:

(A) The federal Supplemental Security Income for the Aged, Blind, and Disabled program set forth commencing with Section 1382, Title 42, United States Code.

(B) The Medically Indigent program for pregnant women, as defined in Section 50251(b)(3).

53910. Organization and Administration.

(a) Each GMC plan shall have the organizational and administrative ability to carry out its contractual obligations, including but not limited to the following:

(1) Each PHP and dental plan shall meet the organizational and administrative requirements contained in Section 53200.

(2) Each PCCM plan shall meet the organizational and administrative requirements contained in Section 56200.

53910.5. Scope of Services.

(a) Each GMC plan shall provide or arrange for the provision of Medi-Cal services in accordance with the requirements for PHPs and PCCM plans, as set forth in Chapters 4 and 6, beginning with Sections 53210 and 56210, respectively, unless services are specifically included or excluded under the terms of the GMC contract, and the following:

(1) Initial medical or dental health assessments. An initial health assessment shall include a history of the member's medical or dental health, an identification of risks, an assessment of need for preventive screens or services and health education, and the diagnosis and plan for treatment of any diseases.

(2) Health education.

(3) Preventive services.

(4) Identification and treatment of disease.

(5) Primary and urgent care.

53911. Availability of Services.

Each GMC plan shall obtain written departmental approval prior to making any substantial change in the availability or location of services to be provided under the GMC contract, except in the case of a natural disaster or emergency circumstances. A proposal to change the location for the provision of covered services or to reduce their

availability shall be given to the department at least sixty days prior to the proposed effective date. The department's denial of the proposal shall prohibit implementation of the proposed changes.

53911.5. Accessibility to Physicians and Dentists.

(a) Each GMC plan that is a PHP or PCCM plan shall retain sufficient professional medical staff to provide access to preventive and managed health care services to its members. Access to physicians shall be as follows:

(1) Each PHP and PCCM plan shall provide at least one full-time equivalent primary care physician for every 2,000 patients, or have in place an alternative mechanism for ensuring access, approved in writing by the department.

(2) Each PHP and PCCM plan shall provide at least one full-time equivalent physician for every 1,200 plan members, or have in place an alternative mechanism for ensuring access, approved in writing by the department.

(3) If utilized by a PHP or PCCM plan, mid-level practitioners, such as nurse practitioners and physicians assistants, shall meet the requirements of existing practice and licensure standards for mid-level practitioners, as specified in Sections 1399.541 and 1470, Title 16, CCR, including physician supervision, as specified in Section 2746.5, Business and Professions Code.

(b) Each dental plan shall establish and implement a mechanism for ensuring access, including but not limited to a maximum ratio of dentists to patients, approved in writing by the department.

(c) Each GMC plan shall ensure that each member of the plan has a primary care provider to supervise and coordinate each member's health care, by either allowing members to select their primary care providers or assigning members to primary care providers, pursuant to Section 53925.

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(3) If utilized by a PHP or PCCM plan, mid-level practitioners, such as nurse practitioners and physicians assistants, shall meet the requirements of existing practice and licensure standards for mid-level practitioners, as specified in Sections 1399.541 and 1470, Title 16, CCR, including physician supervision, as specified in Section 2746.5, Business and Professions Code.

(b) Each dental plan shall establish and implement a mechanism for ensuring access, including but not limited to a maximum ratio of dentists to patients, approved in writing by the department.

(c) Each GMC plan shall ensure that each member of the plan has a primary care provider to supervise and coordinate each member's health care, by either allowing members to select their primary care providers or assigning members to primary care providers, pursuant to Section 53925.

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(2) Each PHP and PCCM plan shall provide at least one full-time equivalent physician for every 1,200 plan members, or have in place an alternative mechanism for ensuring access, approved in writing by the department.

(3) If utilized by a PHP or PCCM plan, mid-level practitioners, such as nurse practitioners and physicians assistants, shall meet the requirements of existing practice and licensure standards for mid-level practitioners, as specified in Sections 1399.541 and 1470, Title 16, CCR, including physician supervision, as specified in Section 2746.5, Business and Professions Code.

(b) Each dental plan shall establish and implement a mechanism for ensuring access, including but not limited to a maximum ratio of dentists to patients, approved in writing by the department.

(c) Each GMC plan shall ensure that each member of the plan has a primary care provider to supervise and coordinate each member's health care, by either allowing members to select their primary care providers or assigning members to primary care providers, pursuant to Section 53925.

53912. Pharmaceutical Services and Prescribed Drugs.

(a) Each PHP and PCCM plan shall provide, either directly or through subcontracts, the services of pharmacies and pharmacists. Pharmaceutical services shall be available to members during service site hours.

(b) Prescribed drugs shall be provided to members by licensed pharmacies and shall be reimbursed by the PHP or PCCM plan in which the member is enrolled. Professional standards reflected by reasonable and current prescribing practices, based on reference to current medical literature and consultation with provider organizations, academic and professional specialists, shall be met, including but not limited to Title 16, Sections 1707.1, 1707.2, and 1707.3.

(c) Prescribed drugs may include the provision of pre-packaged drugs dispensed under the direct supervision of the professionally licensed personnel of the PHP or PCCM plan after the plan has written approval granted by the department.

(d) Each dental plan shall provide written prescriptions to members as necessary, and shall instruct each member to fill any prescriptions at a pharmacy used by the PHP or PCCM plan in which the member is enrolled. The PHP or PCCM plan in which the member is enrolled shall reimburse the pharmacy for each prescription filled.

53912.5. Care Under Emergency Circumstances.

(a) Each GMC plan shall meet the requirements specified in Section 53216.

(b) Each GMC plan shall arrange for and make payment, at the lowest of the Medi-Cal fee-for-service rate or the plan negotiated rate, for emergency services as defined in Section 51056.

(c) Each GMC plan shall make payment, at the lowest of the Medi-Cal fee-for-service rate or the plan negotiated rate, for the diagnostic portion of any emergency room or urgent care visit. Specifically, each plan shall reimburse and shall not require prior authorization for the following:

(1) Emergency room services required to determine whether a member's condition requires emergency services.

(2) All other capitated services, such as radiology or pathology, necessary to diagnose the possible emergency condition.

(d) A GMC plan may authorize and reimburse services provided beyond those required to determine whether the condition is an emergency.

53913. Facilities, Service Locations and Equipment.

(a) Each GMC plan shall comply with the requirements contained in Section 53230, and shall assure proper sterilization and disinfection of equipment, in accordance with California Occupational Safety and Health Administration (Cal/OSHA) standards, pursuant to California Labor Code, Section 6305.

53913.5. Medical Director and Dental Director.

(a) Each PHP and PCCM plan shall appoint a physician as medical director and each dental plan shall appoint a dentist as dental director, whose responsibilities shall include, but not be limited to, the following:

(1) Ensuring that medical or dental decisions are rendered by qualified medical or dental personnel, unhindered by fiscal or administrative management.

(2) Ensuring that the medical or dental care provided meets the standards for acceptable medical and dental care.

(3) Ensuring that medical or dental protocols and rules of conduct for plan medical or dental personnel are followed.

(4) Developing and implementing medical or dental policy.

(5) Resolving medical or dental quality of care related grievances. The medical or dental director shall refer non-medical or non-dental related grievances, and other grievances that are determined to be appropriately resolved through the grievance procedure, to the grievance coordinator.

(6) Actively participating in the functioning of the plan grievance procedures.

53914. Member Grievance Procedures.

(a) Each GMC plan shall establish and maintain written procedures for the submittal, processing, and resolution of all member grievances and complaints. The grievance system shall include the handling of complaints and shall:

(1) Operate according to the written procedures, which shall be approved in writing by the department prior to use. Amendments shall be approved in writing by the department prior to implementation of the revised procedure.

(2) Be described in information sent to each member upon enrollment in the GMC plan and annually thereafter, pursuant to Sections 53926.5 and 53927. The description shall include:

(A) An explanation of the GMC plan's system for processing and resolving grievances, and how a member is to use it.

(B) A statement that grievance forms are available in the office of each primary care provider, or in each member services department of the GMC plan, in the case of a GMC plan in which all primary care providers are the exclusive providers of that plan and are contiguously located.

(C) A statement that grievances may be filed in writing or verbally directly with the GMC plan in which the member is enrolled or at any office of the GMC plan's providers.

(D) The telephone number a member may call to obtain information, request grievance forms, and register a verbal grievance.

(E) A statement that a member has a right to request a fair hearing, pursuant to Section 50951.

(b) Each GMC plan shall make local or toll-free telephone service available to members during normal business hours for requesting grievance forms, filing verbal grievances, and requesting information.

(c) Each GMC plan shall provide upon request a grievance form, either directly or by mail if mailing is requested to any member requesting the form.

(d) Each GMC plan shall provide assistance to any member requesting assistance in completing the grievance form.

(e) The member grievance procedures shall at a minimum provide for:

(1) The recording in a grievance log of each grievance received by the GMC plan, either verbally or in writing. The grievance log shall include the following information:

(A) The date and time the grievance is filed with the GMC plan or provider.

(B) The name of the member filing the grievance.

(C) The name of the GMC plan provider or staff person receiving the grievance.

(D) A description of the complaint or problem.

(E) A description of the action taken by the GMC plan or provider to investigate and resolve the grievance.

(F) The proposed resolution by the GMC plan or provider.

(G) The name of the GMC plan provider or staff person responsible for resolving the grievance.

(H) The date of notification of the member of the proposed resolution.

(2) The immediate submittal of all medical or dental quality of care grievances to the medical or dental director for action.

(3) The submittal, at least quarterly, of all quality of care grievances to the GMC plan's quality assurance committee for review and appropriate action.

(4) The mailing of a written notice of the proposed resolution to the member. Each notice shall include information about the member's right to request a fair hearing pursuant to Section 50951.

(f) Grievance forms and a grievance log shall be available in the offices of each of the GMC plan's primary care providers, or in each member services department of the GMC plan, in the case of a GMC plan in which all primary care providers are the exclusive providers of that plan and are contiguously located.

(g) Each GMC plan shall adhere to the following requirements and time frames in processing member grievances:

(1) Member grievances shall be resolved within thirty days of the member's filing the grievance.

(2) In the event resolution is not reached within thirty days, the member shall be notified in writing by the GMC plan of the status of the grievance and shall be provided with an estimated completion date of resolution.

(h) Each GMC plan shall maintain in its files copies of all grievances, the responses to them, and logs recording them for a period fo five years from the date the grievance was filed.

(i) Any member whose grievance is resolved or unresolved shall have the right to request a fair hearing, in accordance with Sections 50951 through 50955.

53914.5. Provider Grievances and Complaints.

(a) A provider of medical or dental services may submit to a GMC plan a grievance or compliant concerning the authorization or denial of a service or the processing payment or nonpayment of a claim by that GMC plan. Each GMC plan shall comply with the provider grievance and complaint requirements specified in Section 56262. These requirements shall apply to PHPs, PCCM plans, and dental plans in the GMC program.

53915. Quality of Care.

(a) Each GMC plan shall provide care which meets or exceeds the standards for medical or dental practice developed by the GMC plan and approved in writing by the department.

Each GMC plan shall use effective professional review in assessing the care provided to its members in accordance with state standards, including but not limited to Title 10, Section 1300.70.

53915.5. Records.

(a) Each GMC plan shall maintain or cause to be maintained all records necessary to verify information and reports required by statute, regulation or contractual obligation for five years from the date of submission of the information or reports. Records and documents shall include but not be limited to:

(1) Working papers used in the preparation of reports to the department.

(2) Reports to the department, specified in Section 53916.

(3) Financial documents.

(4) Medical or dental records.

(5) Prescription files.

(b) Each GMC plan shall retain or cause to be retained all records pertaining to pending litigation or litigation in progress until the litigation is final.

53916. Reporting.

(a) Each GMC plan shall submit to the department:

(1) Reports required in Section 53312.

(2) Reports specified in the GMC contract.

(3) As frequently as it changes, an updated listing of the GMC plan's provider network, by specialty.

(b) Each GMC plan shall submit to the local health department, reports specified in the GMC contract.

53920. Marketing.

(a) Each GMC plan shall limit its marketing activities to printed and illustrated materials, and media advertising.

(1) Printed and illustrated materials may be made available to members or prospective members, as follows:

(A) By mail. Printing, postage, and any related costs of material mailed to prospective members shall be paid by the GMC plan. Mailings shall be coordinated with the department so that the confidentiality of Medi-Cal beneficiaries is protected.

(B) By posting materials in public places.

(C) At GMC options presentations, which shall be conducted by the GMC enrollment contractor, pursuant to Section 53923.

(b) All printed and illustrated materials and media scripts shall be approved in writing by the department prior to distribution to members or prospective members.

(c) No representative of a GMC plan shall contact prospective members for the purposes of marketing, unless that contact is approved in writing by a coordinated through the department, pursuant to (a)(1)(A), above. However, physicians, dentists, mid-level practitioners, nurses, office staff may discuss GMC plan membership with their patients.

53920.5. Marketing and Member Materials.

(a) The Evidence of Coverage, disclosure form, and any marketing brochure developed by or for a GMC plan and distributed to prospective members shall meet the requirements contained in Section 1300.63(a), Title 10, as to print size, readability, and understandability of text.

(b) All marketing materials distributed to eligible beneficiaries by a GMC plan shall fully disclose the availability of and restrictions upon the services provided by the GMC plan, and any exclusions from coverage. Marketing materials shall, at a minimum, specify:

(1) The scope, access to, and availability of services, including service site locations and telephone numbers, and the service area authorized in that GMC plan's GMC contract.

(2) A description of the membership identification card issued by the GMC plan, if applicable, and an explanation as to its use in authorizing or assisting members to obtain services.

(3) That members shall obtain all Medi-Cal covered nonemergency health care services through the GMC plan's providers.

(4) That medical or dental services required in an emergency may be obtained from specified GMC plan providers or from non-plan providers, if necessary.

(5) The disenrollment process, and an explanation that disenrollment is possible only under the conditions specified in Section 53925.5 and is effective only after the disenrollment transaction is completed by the department.

(6) The GMC plan's grievance process, including instructions on how to use it.

(7) That members have the right to a fair hearing, including instructions on how to request one.

(8) The interpretive, linguistic, and cultural services available through plan personnel.

(9) Any transportation services to service sites that are available through the GMC plan or under the Medi-Cal program. This shall include a description of both medical and non-medical transportation services, and the conditions under which non-medical transportation is available to members, if available.

53921. Member Enrollment.

(a) Enrollment in GMC plans shall be mandatory for those eligible beneficiaries specified in Section 53906(a), and voluntary for those specified in Section 53906(b).

(b) Enrollment shall be limited to eligible beneficiaries who reside within the GMC program area.

(c) The department or the GMC enrollment contractor shall mail an enrollment form and GMC plan information to each eligible beneficiary described in Section 53906(a). The mailing shall include GMC options presentation information and instructions to enroll in GMC plans within thirty days of the postmark date on the mailing envelope.

(d) Each eligible beneficiary described in Section 53906(a) shall enroll in GMC plans within thirty days of receipt of an enrollment from with instructions from the department or the GMC enrollment contractor to select GMC plans.

(1) In the event an eligible beneficiary described in Section 53906(a) does not enroll in GMC plans within thirty days, the GMC enrollment contractor shall assign the eligible beneficiary to GMC plans, in accordance with Section 53921.5.

(2) For purposes of selection of GMC plans:

(A) In the case of a family group, eligible beneficiary means the individual or entity with legal authority to make a choice on behalf of dependent family members.

(B) In the case of a foster care child, eligible beneficiary means the entity with legal authority to make a choice on behalf of the child.

(e) Each eligible beneficiary enrolling in a GMC plan shall enroll in a dental plan and either a PHP or PCCM plan. An eligible beneficiary shall not be enrolled in more than one PHP or PCCM plan and one dental plan at any one time.

(f) The GMC enrollment contractor shall process all enrollments.

(g) An eligible beneficiary is enrolled upon completion of all of the following events:

(1) Either of the following enrollment activities:

(A) The voluntary signing and dating by the eligible beneficiary of an enrollment form and departmental validation of the beneficiary's enrollment form; or

(B) The assignment, as specified in Section 53921.5, of an eligible beneficiary to a PHP or PCCM plan and a dental plan.

(2) Departmental verification of the beneficiary's Medi-Cal eligibility.

(3) Addition of the beneficiary's name to the approved list of members, which is effective the first day of any given month and which is furnished monthly to the GMC plan by the department.

53921.5. Assignment of Eligible Beneficiaries to GMC Plans.

(a) The GMC enrollment contractor shall assign an eligible beneficiary described in Section 53906(a) to a GMC plan, from which to receive health care services, in the following situations:

(1) In the event the eligible beneficiary does not select a PHP or PCCM plan and a dental plan within thirty days of receiving an enrollment form pursuant to Section 53921(c).

(2) In the event a member requests and is granted disenrollment from a GMC plan, pursuant to Section 53925.5, but does not select a different GMC plan in which to enroll, unless that member was granted approval by the GMC enrollment contractor to receive health care services through the fee-for-service Medi-Cal program, pursuant to Section 53923.5.

(b) In carrying out (a), the GMC enrollment contractor shall comply with the equitable distribution requirements contained in Section 53922.

53922. Equitable Distribution.

(a) The GMC enrollment contractor shall implement a system approved by the department to assign an eligible beneficiary described in Section 53906(a), to GMC plans, in the event the beneficiary does not select GMC plans pursuant to Section 53921(d).

(b) The assignment shall ensure the equitable distribution of eligible beneficiaries among GMC plans and include but not be limited to the following considerations:

(1) Zip code of eligible beneficiary matched to zip codes served by the GMC plan.

(2) Enrollment capacity and availability of the GMC plan.

(3) GMC plan's ability to render linguistically appropriate services and the eligible beneficiary's need for those services, if made known to the GMC enrollment contractor.

(4) Rotation of assignments among all GMC plans.

53922.5. Travel Distance Standards.

(a) No member who is assigned to GMC plans pursuant to Section 53921.5 shall be denied a request for disenrollment if all primary health care services through that assigned GMC plan are more than ten (10) miles from the eligible beneficiary's place of residence.

(b) An eligible beneficiary may voluntarily choose to receive services from a GMC plan with service sites exceeding the maximum distance specified in (a).

53923. Options Presentation.

(a) The GMC enrollment contractor shall provide a presentation of GMC plan options to each new and continuing eligible beneficiary who requests a presentation.

(b) The GMC options presentation shall include, at a minimum, the following information:

(1) The names of each GMC plan.

(2) Each GMC plan's service area.

(3) The locations of each GMC plan's service sites.

(4) Services covered by GMC plans.

(5) Procedures for accessing and receiving health care servicesfrom GMC plans.

(6) Hospitals used by each PHP and PCCM plan.

(7) Any features or additional services provided by each GMC plan that are beyond those that must be covered by GMC plans, pursuant to the GMC contract, such as non-medical transportation services, languages spoken, health promotion, risk reduction, health education and counseling services.

(8) An explanation that an alternative to GMC plan enrollment exists for Indians, members of Indian households, and others eligible to receive health care services through an Indian Health Service program facility, and for individuals with complex medical conditions, as specified in Section 53923.5(b).

(9) Assistance to eligible beneficiaries in completing the enrollment form, as needed.

53923.5. Alternative to GMC Plan Enrollment.

An eligible beneficiary specified in Section 53906(a) who meets the requirements of (a) or (b) may request from the GMC enrollment contractor an alternative to GMC plan enrollment.
(a) An eligible beneficiary who is an Indian, is a member of an Indian household, or has written acceptance from an Indian Health Service program facility to receive health care services through that facility, may, as an alternative to GMC plan enrollment and upon request, choose to receive health care services through an Indian Health Service program facility. Any request for this alternative shall be made to the GMC enrollment contractor at the GMC options presentation or through the problem resolution process specified in Section 53926.

(b) On or before March 31, 1995, an eligible beneficiary who is receiving treatment or services for a complex medical situation from a physician who is participating in the Medi-Cal program, but is not a contracted provider of any GMC plan, may request through the problem resolution process specified in Section 53926, continued fee-for-service Medi-Cal for the purposes of continuity of care. The department shall review on a case-by-case basis and make a determination on each request presenting a complex medical situation. The department may approve continued treatment under the fee-for-service Medi-Cal program for any eligible beneficiary whose diagnosis or treatment needs are verified in writing by the beneficiary's Medi-Cal provider and meet one of the criteria below in 1 through 3 for continued fee-for-service Medi-Cal.
(1) The eligible beneficiary is under the care of a physician specialist:

(A) For treatment of a condition that is within the specialist's scope of practice, pursuant to the Business and Professions Code;

(B) That specialty is not practiced by any physician within the available providers of any GMC plan; and

(C) That specialist is a participating Medi-Cal provider, but is not a contracted provider of any GMC plan.

(2) The eligible beneficiary is in a complex, high risk medical treatment plan:

(A) Under the supervision of a physician who is a participating Medi-Cal provider, but is not a contracted provider of any GMC plan; and

(B) May experience deleterious medical effects if that treatment were to be disrupted by leaving the care of that physician to begin receiving care from a GMC plan physician.

(3) The eligible beneficiary is a woman who is pregnant and under the care of a physician who is a participating Medi-Cal provider, but is not a contracted provider of any GMC plan.

(c) Any eligible beneficiary granted continued fee-for-service Medi-Cal under (b)(1) or (2) may remain with that fee-for-service physician only until the medical condition has stabilized to a level that would enable the eligible beneficiary to change physicians and begin receiving care from a GMC plan physician without deleterious medical effects. An eligible beneficiary granted continued fee-for-service Medi-Cal under (b)(3) may remain with that physician through delivery and the end of the month in which ninety days post-partum occurs.

(d) The department may verify the medical conditions and treatment plans presented by an eligible beneficiary, pursuant to (b), to confirm their complexity, validity, and status.

53924. Enrollment/Disenrollment Form.

(a) The department shall develop a combined enrollment/disenrollment form and shall provide it to GMC plans and the GMC enrollment contractor.

(b) Each GMC plan shall send an enrollment/disenrollment form to each member, as specified in Section 53926.5.

(c) Each GMC plan shall make enrollment/disenrollment forms available during business hours:

(1) At each service site. In the case of a GMC plan in which all primary care providers are the exclusive providers of that plan and are contiguously located, enrollment/disenrollment forms shall be available, at a minimum, in the member services department of the plan.

(2) At each member services department.

(d) Each GMC plan shall provide an enrollment/disenrollment form to a member immediately if requested in person, or by mail if requested by telephone or in writing. The GMC plan shall mail the form within three working days of receiving the request.

(e) The GMC enrollment contractor shall make enrollment/disenrollment forms available at the GMC options presentation. The GMC enrollment contractor shall mail a form to a member within three working days of receiving a telephone or written request for a form.

53924.5. Enrollment/Disenrollment Form Processing.

(a) Members shall submit enrollment/disenrollment forms to the GMC enrollment contractor for processing.

(b) Unless otherwise notified in writing by the department, the GMC enrollment contractor shall accept and process all requests for enrollment from eligible beneficiaries up to the maximum enrollment levels specified in each plan's GMC contract.

(c) The GMC enrollment contractor shall transmit all completed enrollment/disenrollment forms to the department within two working days of the date the GMC enrollment contractor receives the completed form.

(d) Each request for disenrollment shall be accompanied by a request for enrollment in another GMC plan. If the member requesting disenrollment does not make an enrollment selection, the member shall be assigned to a plan in accordance with Section 53921.5.

(e) The GMC enrollment contractor shall accept enrollment/disenrollment forms regardless of the prospective member's race, creed, color, religion, age, sex, national origin, ancestry, marital status, sexual orientation, or physical or mental disability, and without reference to pre-existing medical or dental conditions.

53925. Assignment of Primary Care Provider.

(a) Each GMC plan shall have a mechanism in place and approved in writing by the department to ensure that each member is assigned to a primary care provider, by either:

(1) Allowing each member to select a primary care provider from the GMC plan's network of affiliated providers, if the member chooses to do so; or

(2) Assigning a primary care provider to each member within forty days from the effective date of enrollment, if the member does not select one within the first thirty days of the effective date of enrollment in the GMC plan.

(A) Assignment conducted pursuant to (a)(2) shall meet both 1 and 2:

1. The member shall be assigned to a primary care provider within the maximum travel distances specified in Section 53922.5.

2. If available within the GMC plan, the member shall be assigned to a primary care provider who is or has office staff who are linguistically and culturally competent to communicate with the member or have the ability to interpret in the provision of health care services and related activities during the member's office visits or contacts, if the language or cultural needs of the member are known to the GMC plan.

(b) Any member dissatisfied with the primary care provider selected or assigned shall be allowed to select or be assigned to another primary care provider. Each GMC plan shall assist its members in changing primary care providers if that change is requested by the member. Any GMC plan physician or dentist dissatisfied with the professional relationship with any member may request that the member select or be assigned to another primary care provider.

53925.5. Disenrollment of Members.

(a) The GMC enrollment contractor shall disenroll any member who requests disenrollment when one of the following conditions and (c) are met:

(1) A member requests disenrollment during the first thirty days of enrollment.

(2) A member requests disenrollment during the second through sixth month of enrollment in a PHP that is a federally qualified Health Maintenance Organization, a PCCM plan, or a dental plan, for good cause, as follows:

(A) To comply with any of the criteria specified in Section 14407.8(b), Welfare and Institutions Code;

(B) To accommodate the needs of a foster care child;

(C) To comply with travel distance standards specified in Section 53922.5; or

(D) To grant an alternative to GMC plan enrollment as specified in Section 53923.5, if the process for obtaining that alternative was initiated prior to the effective date of enrollment in a GMC plan.

(3) A member requests disenrollment after having met the six-month minimum enrollment period applicable to enrollment in any PHP that is a federally qualified Health Maintenance Organization, a PCCM plan, or a dental plan.

(4) Any member of a PHP that is not a federally qualified Health Maintenance Organization shall be granted disenrollment from that PHP at any time.

(b) The GMC enrollment contractor shall determine whether to grant a request for disenrollment made by a member during the second through sixth month of enrollment. A disenrollment request from a member enrolled in a PHP that is a federally qualified Health Maintenance Organization, a PCCM plan, or a dental plan, shall be granted by the GMC enrollment contractor if one of the criteria specified in (a)(2) is met.

(c) Each disenrollment request shall be accompanied by an enrollment request for enrollment in a different GMC plan. Any member who does not select another GMC plan shall be assigned to one, in accordance with Section 53921.5.

(d) A member who requests and is denied disenrollment during the second through sixth month of enrollment shall have the right to request assistance from the GMC enrollment contractor in accordance with Section 53926.

53926. Problem Resolution Process for Members.

(a) Any member may request assistance from the GMC enrollment contractor in resolving problems associated with mandatory participation in the GMC program, assignment to a GMC plan, enrollment, or disenrollment.

(b) The request for assistance from the GMC enrollment contractor shall be in writing and shall state the nature of a problem.

(c) The GMC enrollment contractor shall prepare a written response and mail it to the member within ten days of receipt of a member's written request for problem resolution.

(d) In the event a member is dissatisfied with the response of the GMC enrollment contractor to a request for problem resolution, the member may file an appeal with the department.

(1) The member shall submit to the department the information specified in (b) and the written response of the GMC enrollment contractor.

(2) The department shall prepare a written decision and mail it to the member within ten days of receipt of a member's appeal.

(e) Each member has the right to request a fair hearing, in accordance with Section 50951.

53926.5. Information to New Members.

(a) Each eligible beneficiary, prior to or upon either signing an enrollment application or being assigned to GMC plans in accordance with Section 53921.5, shall be informed in writing by the department or the GMC enrollment contractor of at least the following:

(1) There will be a 15 to 45 day processing time between the date of application and the effective date of enrollment in GMC plans.

(2) Until GMC plan enrollment is effective, the beneficiary may receive Medi-Cal covered health care services from any Medi-Cal provider licensed to provide the services.

(3) An alternative to GMC plan enrollment exists.

(4) Disenrollment from certain GMC plans, specified in Section 53925.5, is restricted during the second through sixth month of enrollment.

(b) Each GMC plan shall provide in writing, in addition to those items of information required by Section 14406, Welfare and Institutions Code, the following to each member within seven days after the effective date of enrollment in the plan:

(1) The effective date of enrollment.

(2) A description of all available services and an explanation of any service limitations, exclusions from coverage or charges for services, when applicable.

(3) The name, telephone number and service site address of the primary care provider selected by the member or instructions to select a primary care provider within thirty days or be assigned to one, in accordance with Section 53925.

(4) An enrollment/disenrollment form and an explanation that it must be used to disenroll from the GMC plan, in the event disenrollment is requested by the member.

(5) Information concerning non-medical transportation available to them under the Medi-Cal program, or offered by the GMC plan, if applicable, and how to receive it.

53927. Annual Information to Members.

(a) Each GMC plan shall revise, if necessary, and distribute the information specified in Section 53926.5(b)(2) to each member or the member's family unit at least once every twelve months.

53927.5. Notification of Changes in Services.

(a) Each GMC plan shall revise and distribute the information specified in Section 53926.5(b)(2) at least thirty days prior to any changes which the GMC plan makes in services provided or in the locations at which services may be obtained, to each member

affected by that change. Notification shall be provided at least fourteen days prior to any changes in cases of unforeseeable circumstances.

53928. Information for Departmental Dissemination.

(a) Each GMC plan shall furnish the department and the GMC enrollment contractor the information required in Section 53926.5(b)(2) and (5), as it changes and upon request, for dissemination to prospective members.